ATTACHMENT 7
Sample Prior Authorization Request Form (PA/RF) for exceptional supplies

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE ? ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number ? Billing Provider	3. Processing Type
I. M. Provider **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**139**
	4. Billing Provider's Medicaid Provider Number **12345678**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A.	❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
518.81 Acute respiratory failure		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
V55.0 Tracheostomy	**12/01/03**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	E1399					**31**	**Trach care kit BID**	**60**	**XXX.XX**
	E1399					**31**	**Trach suction catheter/every shift**	**90**	**XXX.XX**
	E1399					**31**	**Trach tube holder every 3 days**	**10**	**XXX.XX**
	E1399	**RR**				**31**	**Compressor**	**30**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges** **XXX.XX**

23. **SIGNATURE** — Requesting Provider I.M. Provider

24. Date Signed **MM/DD/YY**

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

❑ Approved

Grant Date _____ Expiration Date _____

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

SIGNATURE — Consultant / Analyst _____ Date Signed _____